NATIONAL SCIENCE FOUNDATION
4201 WILSON BOULEVARD
ARLINGTON, VIRGINIA 22230

OFFICE OF POLAR PROGRAMS

AUTHORIZATION FOR TREATMENT OF FIELD-TEAM MEMBER/PARTICIPANT UNDER THE AGE OF 18 YEARS

I am the parent or guardian of ____________________, who is an under age participant in the United States Antarctic Program. Should any medical/dental care be required during his or her deployment to Antarctica, I hereby give my authorization and consent to the United States Antarctic Program's medical care provider(s) for any medical care, treatment or procedures that are deemed medically necessary while he or she is in Antarctica.

______________________________________ ______________________________________
Name of Parent or Guardian Signature and Date

Address____

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Telephone Numbers: Daytime: ______________________ Evening: __________________________